

Voices from the Trenches: Harm Reduction and Public Policy

by John Newmeyer and Marsha Rosenbaum

The present authors have both been engaged for many years in the study of substance use and its relation to HIV disease. Dr. Newmeyer has been based at the Haight-Ashbury Free Clinic since 1971. He has specialized in the methodology of incidence and prevalence of substance use— i.e., the size and rate of change of “hidden” populations. In 1983, he became involved in the epidemiology of HIV disease among substance users, again with a focus on “hidden” incidence and prevalence. At that time, the HIV epidemic curve among injection drug users (IDUs) was just taking off in San Francisco; realizing this, Dr. Newmeyer turned his energies to “action research in the trenches of the war on HIV.” He and several colleagues developed San Francisco’s four-pronged HIV prevention strategy for IDUs: (1) spread the word among the drug users that HIV poses a dire risk to their health, (2) urge them to get treatment to assist in beginning and sustaining abstinence, (3) for those who continue using needles, urge them never to share hypodermic equipment, (4) for those who continue to share, urge them to disinfect the equipment between users.

The key innovations that emerged from the work of Dr. Newmeyer and his colleagues were “the little bleach bottles”— portable one-ounce plastic bottles of bleach to enable quick, easy disinfection of “works”— and “Community Health Outreach Workers” (CHOWs)— streetwise people paid to locate and educate IDUs about HIV prevention. The first team of seven CHOWs was fielded in 1986 by the MidCity Consortium to Combat AIDS; Dr. Newmeyer conducted both qualitative and quantitative research on the CHOWs’s work: the ethnography of their relationship with the user communities, the cost-efficiency of their work, the impact upon HIV incidence and prevalence among IDUs, et cetera. Beginning in April 1988, Dr. Newmeyer authored and published a monthly newsletter, MidCity Numbers, which discussed the “numbers” aspects of HIV disease and substance use. This newsletter was distributed to the several hundred persons in the San Francisco Bay Area who were involved in HIV prevention, drug abuse treatment, or related endeavors.

[one or two paragraphs about Marsha Rosenbaum's work with women's issues, at the Lindesmith Center, et cetera. Mention should be made of her commitment to "action research" that can directly reduce the spread of HIV]

Dr. Newmeyer's and Dr. Rosenbaum's work has been conducted in a public policy environment which apparently in large part-- worldwide but especially in the United States-- has *contributed* to the spread of HIV. Chief among the counterproductive drug policies in the U.S. are these:

- Resistance to needle exchange programs, even those programs which had been carefully designed not to increase the amount of "works" in the community, nor to supply noninjectors with needles. Dr. Peter Lurie estimates that between 4,000 and 10,000 extra HIV infections resulted from the U.S. government's failure to accept needle exchange at the time the scientific community first urged such acceptance.^o
- Failure to promote "bleach disinfection" effectively among IDUs.
- Unrealistic drug treatment policies which promoted abstinence at the exclusion of harm reduction.
- Failure to fund fully abstinence-oriented drug treatment programs, so that even this modality has been characterized by long waits for entry into treatment.

These counterproductive policies are rooted in the way in which drug use is perceived, and the drug education strategies deriving from that perception. Drug education in the U.S. is based on several questionable assumptions about adolescence and drug use: (1) total abstinence is a realistic goal; (2) the use of illegal substances necessarily means abuse; (3) one form of drug use inevitably leads to other, more harmful forms; (4) understanding the risks inherent in drug use will deter children from experimentation; and (5) children are incapable of making responsible decisions about an issue as serious as drug use.

Contemporary drug education programs have as their underlying premise the futile goal of *abstinence* from all illegal drugs. The

expectation that adolescents will not experiment with altered states of consciousness is unreal at best.^{2,3} Championing abstinence has thus led to the inevitable failure of programs that have made this their primary goal because some form of drug use is nearly universal, and certainly integral to American culture.⁴ Thus, drug education programs, by virtue of their most basic assumption, are doomed to fail.

Another assumption pervading drug education is that *use* is equal to *abuse*. Some programs use the terms interchangeably while others utilize an exaggerated definition of use that results in defining anything other than one-time experimentation as abuse. A problem with the blurring of distinctions between use and abuse is the inconsistency with students' observations or experiences. When young people are told that one-a-month use of a substance is abuse, they often snicker. They see others, and often themselves, as people who have used an illegal substance without any of the addictive or deleterious effects that would constitute "abuse". No consensus exists as to which behaviors constitute drug use or drug abuse. Programs that do not differentiate between these two are therefore ineffective.^{5,6}

A theory inherent in drug education is the "gateway" or "stepping stone" hypothesis. This theory argues that alcohol and cigarettes are "stepping stones" to illegal drugs, and the "softer" illegal drugs such as marijuana are the gateway to "harder" drugs such as cocaine and heroin.⁷ There is no evidence, however, that the use of one drug leads to another, and several studies have found that the vast majority of students who do try drugs do not become abusers.⁸

Another premise of drug education is that if children simply understood the dangers of drug experimentation they would abstain.⁹ In the effort to encourage abstinence, "risk" and "danger" messages are often exaggerated. Aside from glaring falsehoods and ridiculous analogies (e.g., the fried egg commercial) these messages are often inconsistent with children's actual observations and experiences. The typical response of children to such contradictory information is to simply discredit the message as in the case of the heroin addict one of us (MR) interviewed in the 1970s. She was a "nice Jewish girl" who came from a middle class suburb in a large metropolitan area.

Genuinely intrigued by her situation, I asked how she had ended up in jail and addicted to heroin. I will never forget what she told me, "When I was in high school they had these so-called drug education classes. They told us if we used heroin we would become addicted. They told us if we used marijuana we would become addicted. Well, we all tried marijuana and found we did not become addicted, so we figured the entire message was b.s. I then tried heroin, got strung out, and here I am."

Finally, most programs are predicated on the notion that teenagers are incapable of making decisions about drug use. Students are given the inconsistent message that although they must resist peer pressure and make their own decisions about drug use, they must always say "no". A common complaint about the DARE program, according to Wysong, Aniskiewicz and Wright, was from students who did not believe their opinions were taken into account:

"It's like nobody cares what we think... The DARE cops just wanted us to do what they told us and our teachers never talked about DARE...It seems like a lot of adults and teachers can't bring themselves down to talk to students...so you don't care what they think either." ¹⁰

Aside from being intelligent, critical thinkers, teenagers sometimes have experienced drug use, before, during and after having received drug education. They often use their own experience and intelligence to decide whether or not to use drugs. In fact, most decide on their own to refrain. Studies conducted to discover the reasons why teenagers quit using marijuana found that health reasons, short term problems and negative drug effects, *based on students' own experience*, motivated them. Thus, any form of drug education should interact with and respect both their ability to reason and their own experiences.¹¹

Not educating young Americans sensibly about drug use is only one of the reasons why our nation's AIDS epidemic has been needlessly worsened. Another major reason is the *absence of strong, effective public health leadership*. San Francisco enjoyed such leadership during its last great epidemic, of influenza in the autumn of 1918. Like AIDS, the "Spanish flu" mostly killed young adults. But unlike AIDS, contagion was extremely swift: the city's caseload doubled every two days between late September and late October. Again unlike AIDS, the response of the San Francisco Public Health

Department was swift. This is what the authorities accomplished in just three weeks in October 1918:

- shut down all schools, theaters, and public gathering places
- forbade church services
- converted Police Department patrol wagons into ambulances, and assigned cops to be medical orderlies
- motivated thousands of citizens to provide simple medical care, or to replace essential workers in the city's infrastructure
- passed an ordinance requiring the wearing of gauze masks
- distributed 100,000 gauze masks in four days
- inoculated 18,000 citizens with a newly-developed flu vaccine

It is not necessarily true that these measures had any effect; Boston, with a minimum of preventive measures of any sort, had roughly the same death rate. Also, then as now, the public chafed at limitations on civil rights, especially the mandate to wear masks during the holiday season. The point, nonetheless, is that the San Francisco authorities *tried their best* to stop the epidemic.

It is sobering to compare this to San Francisco's response to AIDS, 65 years later. In June 1983, one of the authors (JN) participated in a meeting at the San Francisco Public Health Department, during which it was clearly stated that the city's IDUs were in imminent danger from an infectious disease which had already killed a hundred New York City IDUs. The meeting participants made a number of suggestions, very like what would be made now except that nobody knew about HIV nor about the specific efficacy of bleach as a disinfectant. Had these suggestions been acted upon with the same alacrity as in 1918, this is what would have happened in the *first three weeks* of July 1983:

- ample broadcast over radio and TV of the "needles transmit AIDS" message
- printing and focused distribution of public health pamphlets meant to inform IDUs of the danger of needles
- establishment of needle exchange programs at 10 or so sites
- funding of extra slots in treatment programs for rapid admission of IDUs at greatest risk for infection

- recruitment of volunteers to locate IDUs on the streets and show them how to disinfect "works" with boiling water or isopropyl alcohol [i.e., the state of the art in 1983]

We don't know what the HIV+ rate was among San Francisco IDUs in mid-1983; the best guess is about 1.5%, a prevalence rate which doubled each year until it reached 12% in 1986. We also don't know how well the above measures would have worked, if at all.

As of 1997, San Francisco has recorded about 1,200 AIDS deaths of IDUs, of which as many as 1,000 could have been avoided if the above-described public health blitz had worked (i.e., if the IDU HIV+ rate had stopped rising at 1.5% rather than 12%.) But the City authorities *chose not even to try*. Will there ever be any punishment for this failure to act? Will there ever be an formal investigation into the matter, a judging of numbers, a naming of names? Of course not. The single great difference between the moral space of public health policymakers now as compared to 1918 is that now they fear being blamed for what they do, whereas then they feared being blamed for what they *didn't* do. This is the central truth about America's failure of public health leadership in regard to AIDS.

This failure becomes more glaringly evident through sad repetition. One of the present authors (JN), in the Summer of 1986, circulated a clarion call for a "nationwide bleach distribution campaign among IDUs" at the National Institute of Drug Abuse. There was no meaningful response. There was the same absence of response to the call issued by [] in 1987 for a nationwide needle exchange effort; the deadly consequences of that absence of response have been examined by Peter Lurie, cited above.

Social class may be part of the reason why America's public health "leadership" failed to lead an effective HIV prevention campaign. IDUs are, after all, predominantly drawn from the relatively powerless classes of our society: the "proletariat", or "lumpenproletariat", or "underclass". It takes many deaths of such individuals to equal, in terms of protest against public-health incompetence, one death of a well-placed bourgeois.

Risky drug use is one major cause of HIV transmission; risky sex is the other. As with drugs, there have been failures in HIV the nation's HIV prevention strategy, for example:

- The failure to create and fund realistic nationwide safer-sex education policies aimed at homosexually active men.
- The lack of emphasis upon the products of safer sex, such as condoms and lubricants.

The common theme running through most of the U.S.'s failed policies is the *reluctance to accept that people will persist in dangerous behaviors, even at the risk of fatal consequences*. The strategy of "harm reduction" is the best response to that persistence.

Harm Reduction

Harm reduction can be most broadly defined as enabling individuals who choose to continue to engage in potentially dangerous behavior to do so in a way which minimizes negative consequences to themselves, their associates, or their communities. As an activity, harm reduction is at least as ancient as the first Sumerian who added water to his wine; harm reduction activities are as diverse as the potentially "harmful" activities people engage in, which of course include innocent pleasures such as sports, marital sex, fishing, or hunting as well as winedinking. As a formal sociological concept, harm reduction is much more recent; the first mention in the literature is [reference]

The policy debate in the United States has been often been conceived as "abstinence *versus* harm reduction", as if the two are antagonistic. In the drug policy arena, the debate echoes the 17th-Century struggle of Roundheads and Cavaliers. In the stereotype of that English Civil War era, the Roundheads are industrious, middle-class, thrifty, sober, and puritan in their religion and lifestyle, while the Cavaliers are carefree, aristocratic, stylish, fun-loving, and easygoing in their religion and politics. The Roundheads are reborn as abstinence adherents, who perceive mankind as divided into the "saved" (clean and sober) and the "damned" (still using). Like the dissenting Protestants, though, these modern Roundheads welcome the redemption of the most wretched alcoholics, and modestly accept themselves as forever sinners, however long-enduring their own sobriety. Meanwhile, Cavaliers are reincarnated as harm reduction enthusiasts, sincere in their cheerful conviction that occasional

intoxication is not ⁱⁿ compatible with risk reduction, and that people can be helped to "have fun and be safe, too".

by The policy framework needs to be reconceived as one of a combined "abstinence *and* harm reduction" grand strategy. This reconception is well established in the alcohol field, as demonstrated by the peaceful and mutually respectful coexistence of teetotaling alcoholics and responsible drinkers at countless social gatherings. The following sections will elucidate our ideas for achieving a similar "mutual ^{and} respectful coexistence" in the realms of sexuality and drug use; most of these ideas are in the direction of encouraging "safer practices" for those persons for whom abstaining from the risky behavior is not yet feasible.

Technical Innovations and Safer Sex

Much can be gained by relatively simple technical fixes in the "things" which help people practice safer sex. Here are the most prominent of these innovations:

- **Improved condoms.** A major problem in safer sex education is, "people want to avoid HIV and know that condoms are a good way to do so, but they don't always use them." The overall attractiveness of condoms is one factor, but surely convenience-- the speed and ease with which a condom can be put on-- is another. The challenge is (1) to make it more likely that, if a condom ~~are~~ is in the room where intercourse is about to happen, it will be used; and (2) to cut as many seconds as possible off the time required for the average Joe to put on the condom. This leads to a few recommendations on condom technology: vj

- Provide condoms in three sizes ("regular", "large", and "extra large") so that men can select for proper fit.
- Package the condom in a hard plastic capsule so constructed that it can be opened by holding it in the hand and flicking the thumb against the side, rather like an old-fashioned somewhat lighter.
- Have the condom generously lubricated, with a water-based, viricidal lubricant of pleasant smell and taste.

- Let the condom be rolled in such a way that the user can tell by touch (i.e., in the dark) which way it unrolls.

The critical question is, will these straightforward improvements actually increase the frequency of condom use by a few percentage points? This question can properly be answered by field testing, as has been done with the female condom. If such testing shows any real prospect for more condom usage, it will create a moral imperative for a prompt mass-marketing and subsidized distribution to Americans for whom high price might deter condom purchase.

To illustrate this issue, let us make three reasonable assumptions:

- (A) That "high risk" American heterosexuals (IDUs, crack users, men who occasionally have sex with men, etc.) generate 20,000 seroconversions a year.
- (B) That 75% of all heterosexual acts of these high risk persons are unprotected by condoms.
- (C) That improvements in the technology of condoms, as described above, can lead to a decrease in unprotected sex from 75% to 72%.

If high-risk heterosexuals have .72/.75, or 96%, as much unprotected sex as before, then it is also reasonable to guess that the seroconversion rate will be $.96 \times 20,000$ or 19,200. That's a saving of 800 seroconversions a year. Even with the conservative assumptions made above-- the true "seroconversions avoided" number is likely to be much larger-- it is surely sufficient to justify serious efforts at condom redesign and distribution.

- **The Female Condom.** The physical strength and/or psychological frailty ("they make me less of a man") of the male partner can mean that he won't use condoms even when his partner wants him to do so. The "female condom", developed by Wisconsin Pharmacal Co., has been demonstrated to have wide acceptability among both gay and straight couples. This enables the receptive partner to make the choice and have the control. To judge from reports of sex industry workers who "hide the condom in my cheek and slip it on the John when I give him a blowjob", many men won't

even know their partners are using a female condom. (So much for the complaint, "condoms take away from the feeling!") As with the male condom, though, research is needed on ways to improve the female condom.

- **Lubricants.** In safe-sex education, condoms are the "thing" by far most often discussed. But another "thing" can play a vital role: lubricants. An ideal lubricant should be water-based, should contain an effective viricide such as nonoxynol-9, and should be contained in a handy tube that's easy to open with one hand in the dark. "Lubes" play a vital role when there is the chance of genital (or rectal) bleeding by either partner, because of lesions, prolonged intercourse, or "rough sex." But more research is needed to develop viricides which don't have undesirable side effects on the genital environment, e.g., on protective vaginal flora.
- **Douches.** A male leaves several milliliters of potentially HIV-infected semen in his sexual partner. Are there effective viricidal douches or gels that she can use, after intercourse, as a preventative measure? This promising prevention method has not yet been adequately researched.
- **Condomania Stores.** Shoppers can now find condoms in many sizes, shapes, colors, flavors, and thinnesses; they can also find lubes, lotions, foams, and other "sex positive" materials.

Educational Innovations for Safer Sex

The advent of HIV has forced us to a more frank examination of people's sexuality. We realized that HIV prevention efforts would be more effective if we approached high-risk people— gay men, female partners of non-monogamous men, adolescents, etc.— in ways that were meaningful and acceptable to them. Arising from this realization are several innovations in "safer sex" education:

- **Outreach.** What a simple idea: pay people to go out among those at high risk for HIV, to furnish them with information and materials to avoid infection, and to return repeatedly to reinforce behavior change. So obvious now, but such a difficult concept for policymakers, physicians, and professors to grasp! One phrase, more than any other, has helped these mandarins to see the light: "It's

much easier to teach HIV wisdom to a streetwise person, than street wisdom to an HIV expert!"

- **"Forgot it? Then, forget it!"** The idea here is to arm women (or men playing the receptor role in anal intercourse) with a few words which can effectively put off a male sexual partner who doesn't have, or won't use, a condom. Hence, "Forgot it [condom]? Then forget it [sex]!" In Great Britain, a popular version goes, "It's not on if it's not on". Many other versions of the basic message, "no sex without a condom!" have been bruited in the prevention literature. The ultimate goal is a paradigm shift for the world: men who won't use condoms are not manly-- they are irresponsible, uncaring louts who just aren't worthy of sexual intimacy.

- **Teach boys to masturbate with condoms.** That is, associate condoms into the imagery of sexual stimulation, so that the condoms become sex-positive rather than sex-negative. Here's where a technical fix can help: let the condoms easy to put on; let them be well-lubricated (to facilitate phallic stimulation) with an attractive aroma; and let the package be adorned with an *incredibly* sexy image. Then distribute these condoms to 14-year-old boys with the admonition, "practice using these, they're gonna be an essential part of your sex life." Of course, the how and where of this last element is the tricky part...

- **"Life, Liberty, and the Pursuit of Happiness".** This was the title of a poster created and distributed in California in 1989. It was among the first American posters to use attractive, "regular-guy" models to get the pro-condom message out to young gay men. The breakthrough innovation was to imply that such men are constitutionally entitled to their fair share of the American pie, i.e., a life free from HIV and enriched by erotic expression.

Structural/Environmental Innovations for Safer Sex

Peter Lurie and Tom Coates (Center for AIDS Prevention Studies) and Dan Wohlfeiler (Stop AIDS Project) organized a meeting, "Structural and Environmental Approaches to HIV Prevention" in November 1996. They wrote, "we often forget that historically it is societal-level public health interventions, not individual-level ones, that have yielded the greatest benefits in terms of preventing disease and

Abbrev.
?

suffering." As three examples of societal-level interventions against HIV, they cited screening of the blood supply, modification of syringe-possession laws, and proactive safer-sex policies of sex clubs. Several new ideas in the area of sexual risk reduction came out of the meeting:

- **Provide incentives for doing sex education.** The idea is straightforward: provide county, State, or Federal incentives to school boards whose middle school and high school kids become smart about their sexuality. But "become smart" must be measurable in ways that please both liberal and conservative critics: less HIV, fewer STDs, fewer teen pregnancies, fewer abortions.

- **Provide incentives for youth for STD screenings and treatment.** Suppose every young person were promised a cash payment (or a pair of athletic shoes, or a sports event ticket, or a skateboard, or a videogame disc) for showing up at the local STD clinic on each birthday. Then suppose the atmosphere of the rooms for receiving these youth was clean, hip, and entertaining. What proportion of the eligibles might show up? A 10% rate would probably dent the local HIV situation; a 50% rate, in certain neighborhoods, would change the course of history...

- **Illuminate the contagion role of high-status men.** A study of the drug scene in Bayview-Hunters Point, San Francisco, by Mindy and Robert Fullilove¹, found that the higher the young men in the dealing hierarchy, the greater their sexual activity-- and the greater their incidence of sexually transmitted diseases. In the same vein, *The Economist* reports that HIV infection in African armies is directly correlated with rank. How does this phenomenon affect the female sex partners of the men? As the women become aware of the situation, will things be different?

- **Conclude how safe (or not) oral sex is.** Let's face it: for many people oral sex with a condom, or a dental dam, just won't do. Of course there is HIV risk from oral sex, but is that risk on the order of one in a thousand, or one in a million? If the risk is comparable to that of a long automobile drive, we need to know-- and be advised appropriately: just as there are safer driving practices, there are also safer techniques of unprotected oral sex. For those for whom oral sex is preferable to anal sex, or an acceptable alternative, the imprimatur of "oral sex is essentially safe" would be immensely

able

liberating. An "AIDS czar" might be to give that imprimatur if it were proven that the per-incident risk of receptive oral sex was less than 1 in 200,000, which is about the risk of death per 500 miles of automobile travel.

- **Distribute condoms in taxicabs and in motels**...or wherever one is likeliest to find couples in the last few minutes prior to their first sexual encounter. Of course, it makes sense also to make condoms freely available in prisons.

Serendipity and Safer Sex

In an era when sexually active people are highly aware of the risks of HIV, but not using the "things" (condoms, lubricants, etc.) that they should, serendipitous risk reduction may nonetheless be happening. Here are choices that people may make, possibly without being aware that their fear of HIV is playing a role:

- By who is picked to have sex with. We tell people that "you can never know who's carrying the virus", but are we sure there isn't some kind of subtle wisdom among sexually active people?
- By how "rough" the sexual play is.
- By how long the male partner keeps his cock inside his partner.
- By choosing not to have sex with the partner a second time in one night (it can be argued that the "second time" is more likely to transmit HIV than the "first time").

It is very difficult to know if any of these factors play a part in reducing the rate of HIV transmission among sexually active men and women. But it does seem possible that people can become "safer" even if they don't use condoms. Of course, prevention efforts should still emphasize the "safest" measures.

A Harm Reduction Approach to Drug Education

Despite billions of dollars in drug prevention efforts, a sizable number of Americans continue to use drugs. Adolescent experimentation with drugs continues as well. Though we cannot eliminate drug use altogether, we can at least try to minimize its dangers. The best we can hope for, in lieu of total abstinence, is responsible use based on informed decisions. We must approach drugs in the same way we approach other potentially dangerous substances and activities. For instance, instead of banning the automobile, which kills far more teenagers than do drugs, we enforce traffic laws, prohibit driving while intoxicated, and insist that drivers wear seat belts. We then likewise teach young adults how to use alcohol responsibly with messages like "know when to say when." We put warning labels on pharmaceutical drugs.

The basic assumptions and goals underlying this type of drug education program are designed to result in *harm reduction*. A harm reduction drug education program has four basic assumptions. First, "drugs" must be categorized broadly to include all intoxicating substances, including those which are legal.

An effective drug education program must acknowledge legal status as a risk factor in itself because becoming involved with the criminal justice system has devastating implications beyond the physical effects of drug use. Teachers must discuss drugs as substances that affect the mind and body, without using legality as a way to distinguish between acceptable and unacceptable drugs. In a drug education curriculum it is imperative to categorize drugs in the broadest way possible, casting off distinctions between legal and illegal drugs in order to educate children about the nature of all psychoactive substances, including alcohol, caffeine, over-the-counter substances, and prescription drugs.

A second basic assumption of a harm reduction education program is that total abstinence is not realistic. Drugs have always been and are likely to remain a part of American culture. We routinely alter our states of consciousness through accepted means such as alcohol, tobacco, caffeine, and prescription medications. Americans are perpetually bombarded with messages that encourage them to medicate with a variety of substances. Since total abstinence is not a realistic goal, we must take a pragmatic rather than moralistic view toward drug use. Like sexual activity, drug use will happen, so instead of becoming morally indignant and punitive, we should

assume the existence of drug use and seek to minimize its negative effects.

A third assumption is that it is possible to use drugs in a controlled responsible way, and the use of mind-altering substances does not necessarily constitute abuse. The majority of drug use (with the exception of nicotine, which is the most addictive of all substances) does not lead to addiction or abuse. Instead, 80-90 percent of users control their use of psychoactive substances.¹² It is a mistake to assume that because responsible users of illegal drugs are not visible that they do not exist. Children could benefit from understanding how others achieve a moderate, responsible lifestyle in which drug use is present but made safe through a variety of conscious mechanisms.

A fourth assumption of a harm reduction drug education program is that perhaps nothing is more crucial regarding safe drug use than context. First, the pharmacology of the drug itself is important, as well as the dosage level. Second, the "set," or psychological state, of the user at the time of use must be understood. Finally, the setting, including geography, social group and even weather affects one's experience of a particular drug. These three elements form the context of use, and make the differences between drug use and abuse, and it is within this context that educational efforts must be placed.¹³

FOOTNOTES

0. Peter Lurie,
1.

2. Andrew Weil, *The Natural Mind*, Boston, MA: Houghton-Mifflin Company, 1972; Joel Fort, *The Addicted Society*, New York: Grove Press, 1981.

3. "Drug Use Among Youth: No Simple Answers to Guide Prevention," GAO Report, December 1993.

4. Chwee Lye Ching, "The Goal of Abstinence: Implications for Drug Education," *Journal of Drug Education*, 11(1), 1981.

5. David F. Duncan, "Problems Associated with Three Commonly Used Drugs: A Survey of Rural Secondary School Students," *Psychology of Addictive Behavior*, 5(2), 1991, pp. 93-96.
6. "Drug Use Among Youth: No Simple Answers to Guide Prevention," GAO Report, December 1993.
7. Denise Kandel, "Stages in Adolescent Involvement in Drug Use," *Science*, v. 190, 1975, pp. 912-914; Steve G. Gabany and Portia Plummer, "The Marijuana Perception Inventory: The Effects of Substance Abuse Instruction," *Journal of Drug Education*, 20(3), 1990, pp. 235-245.
8. Brown, J.H. and Horowitz, J.E., "Deviance and deviants: Why adolescent substance use prevention programs do not work" *Evaluation Review*, 17(5), 1993, pp. 529-555; Lynn Zimmer and John Morgan, *Exposing Marijuana Myths: A Review of the Scientific Evidence*. New York: Open Society Institute, October 1995, p. 14.
9. Jerald G. Bachman, Lloyd D. Johnston, and Patrick O'Malley, "Explaining the Recent Decline in Cocaine Use Among Young Adults: Further Evidence that Perceived Risks and Disapproval Lead to Reduced Drug Use," *Journal of Health and Human Social Behavior*, 31(2), June 1990, pp. 173-184.
10. Earl Wysong, Richard Aniskiewicz, and David Wright, "Truth and DARE: Tracking Drug Education to Graduation and as Symbolic Politics," *Social Problems*, 41(3), August 1994.
11. Chorsie E. Martin, David F. Duncan, and Eileen M. Zunich, "Students Motives for Discontinuing Illicit Drug Taking," *Health Values: Achieving High Level Wellness* 7(5), September-October 1983, pp. 8-11.
12. Thomas Nicholson, "The Primary Prevention of Illicit Drug Problems: An Argument for Decriminalization and Legalization," *The Journal of Primary Prevention*, 12(4), 1992; Charles Winick, "Social Behavior, Public Policy, and Nonharmful Drug Use," *The Milbank Quarterly*, 69(3), 1991.
13. For an interesting discussion of the role of context in cross cultural settings, see Charles Grob and Marlene Dobkin de Rios, "Adolescent Drug Use in Cross-Cultural Perspective," *The Journal of Drug Issues*, 22(1), 1992.

0 45 90 135 180 135 90 45

90° N

~~Pole~~

45° N

France

~~ATI~~

Wisc

~~Pac~~

~~Pac~~

Sib

Sib

Rus

E

~~ATI~~

~~ATI~~
↓

~~Pac~~

~~Pac~~

~~Pac~~

~~Pac~~

~~Ind~~

~~Ind~~
↓

45° S

~~ATI~~

~~ATI~~

~~Pac~~

~~Pac~~

~~Pac~~

~~Pac~~

~~Ind~~

~~Ind~~

90° S

Pole

6 of 26

Common safe-sex practices among gay men are mutual masturbation and frottage (a.k.a. intracrural intercourse, "thigh sex", "the Princeton rub", etc.). Often one man ejaculates before the other, and his semen is used as a lubricant for the other's cock. If the first partner's semen contains HIV, is there a risk for the other?

COMMON THEMES

Three themes are common to these innovations:

Technological simplicity. No million-dollar machines, no billion-dollar hospitals, no unpronounceable miracle drugs-- just a little ingenuity and common sense applied in a new way.

The irrelevant mandarins. As far as I know, none of the people who came up with these ideas were part of the political or medical Establishment. In fact, that Establishment put up considerable resistance to many of the innovations. With the single shining exception of Surgeon General Koop, the actions of these "leaders" have not meant that we are burying fewer of our friends.

The muse of California. Most of the innovations were created in California, and the others found fertile ground there immediately after their creation elsewhere. What is it about the Golden State?